Tips about Trauma-Informed Practices
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Amy Judy (of the Vera Institute of Justice) asked me to give you a little background on trauma-informed practices and to talk with you about the Domestic Violence and Mental Health Collaboration Project’s work on trauma-informed practices. I imagine many of you are already very familiar with the framework of trauma-informed care and it is certainly possible that you have more expertise in this area than I do. I hope that there will still be some value for you in what I am about to share. If you are new to this approach or if you have heard the term “trauma-informed” a lot and are not sure what it means, then I hope I can shine some light on that for you.

I realize most of you are muted and that I cannot see any of you, but go ahead and nod your head if you like storytelling. The story I am telling myself right now is that you are all nodding vigorously. The truth is that we all tell ourselves stories a good deal of the time. If someone does something nice for you, you might tell yourself a little story about why. If someone does something like cut you off in traffic, then you might tell yourself a little story about why. If someone does something like cut you off in traffic, then you might tell yourself a little story about that. The traffic story is probably not as nice as the first one.

If you want to get fancier with your language when describing this phenomenon of storytelling, you can talk about cognitive schemas. “Cognitive schema” is lingo psychologists use to describe how we use little mental shortcuts to organize and to interpret the vast amounts of stimuli and data that we are constantly experiencing. We need these shortcuts because, as impressive as we all are, we do not have the capacity to engage in profound critical analysis about everything we experience.

Unfortunately, many people use negative cognitive schemas or negative mental shortcuts when they encounter trauma survivors with disabilities, particularly if those people are behaving in ways that seem atypical or are communicating in a way that is not perfectly clear, coherent, or consistent, or if they are making choices that might not make sense to us on the surface.
In this type of a situation, a person might be thinking to themselves, “What is wrong with this person?” or telling themselves a little story about what they think is likely wrong with that person. This could be because of bias, but it is not necessarily because of that. It is also not that all people are inherently mean, but because many of us have been socialized to see people through a deficit model or medical model that focuses on what is wrong with people. This might be because some people find that to be an important first step in identifying what can be fixed or improved. Or, this might be because people feel safer if they do not think they have the same “flaw” as the person who has suffered or is suffering. Unfortunately, this can lead to treating people poorly, oppressing them, and to not feeling very good about ourselves.

**Trauma-informed practices** are about shifting our focus from the negative mental shortcut of “What is wrong with this person?” to the more compassionate, supportive, and respectful mental shortcut of “What has happened to this person?” It is about telling ourselves stories that involve seeing the trauma survivor as a protagonist who may have suffered but who is overcoming obstacles or who is working to get their needs met. When you think to yourself, “This survivor is really struggling to get their needs met,” or “I wonder what is happening here that I might not understand,” it feels very different than when you think to yourself, “This person is really manipulative.”

So, at its essence, trauma-informed care is about changing ourselves and our own reactions to people; it’s not about changing other people. It is about changing the lens with which we view others, and the stories we tell ourselves as a result. And ultimately, it is about changing how we treat people and react to the conditions that cause their suffering.

Of course, when we change the stories we tell ourselves, we might also feel compelled to learn more about trauma, the neuroscience of trauma, and how to respond effectively to people who have experienced trauma. We might also want to look at our philosophy around providing care, our policies and procedures, the environments in which we offer services, and the services themselves. This hopefully will lead to exploring further how our work intersects with social justice efforts and the conditions that lead to so much trauma. **Responding to trauma without working to prevent it can exacerbate problems with secondary traumatization because it can contribute to a sense of helplessness. That can be true for service providers and for service recipients.**

I could go on and on about that, but instead I will tell you a little bit about our Trauma-Informed Practices Initiative and share some tips with you. That is an acronym pun in case you missed it - **Trauma-Informed Practices…T-I-P.** Now, I am now picturing you all grimacing. 😊
Our Collaboration Project implemented a Trauma-Informed Practices Initiative where we worked on educating ourselves and changing each of our agencies to become more trauma-informed. We:

- Learned the basics of trauma-informed care;
- Had training on trauma-informed supervision;
- Learned how to facilitate *Seeking Safety*, a trauma-responsive group curriculum; and
- Each organization identified and implemented trauma-informed workplace plans.

Here are some tips for trauma-informed activities our partner organizations did that you also might want to consider:

- Developing Wellness Recovery Action Plans (WRAPs) for staff;
- Changing questions used in case consultations to focus on “What has happened to...” instead of “What is wrong with...” the service recipient;
- Drafting philosophy of care statements that include trauma-informed response;
- Changing intakes to include trauma-informed questions;
- Focusing on trauma-informed supervision practices; and
- Offering trauma-responsive services such as *Seeking Safety* groups.

One of our mental health partner organizations shared that staff felt better about their work and their clients after making trauma-informed changes at their agency because they no longer viewed clients as being manipulative or felt bad because they felt like they had been manipulated. Instead, they were more likely to see their clients as people who had been hurt and were trying to get their needs met, but did not yet have healthy strategies for achieving that or the support system they needed to do so. They also viewed their clients more from a strengths-based perspective than from a deficit or disordered perspective, and that felt better for everyone.

Anyhow, I will stop my storytelling now and give all of you a chance to speak! If you have any questions about what I just said or about the handout I put together, please let me know. The handout is available at [http://endgv.org/projects/domestic-violence-mental-health-collaboration-project/](http://endgv.org/projects/domestic-violence-mental-health-collaboration-project/).

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